Arizona Health Care Cost Containment System
Arizona Department of Health Services

Children's Rehabilitative Services

Report for Contract Year 2004

External Quality Review Organization Annual Report

Submitted by
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Phoenix, Arizona

EQRO Annual Report
Contract Year 2004
Children's Rehabilitative Services
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EXECUTIVE SUMMARY

The purpose of the EQRO Annual Report is to evaluate the Children's Rehabilitative Services Administration's (CRSA's) compliance with the Balanced Budget Act of 1997 (BBA) requirements applicable to CRS as a prepaid inpatient health plan (PIHP). The review is limited to three areas: performance measures, performance improvement projects, and compliance with Medicaid managed care federal and state regulations.

The CRS program is administered through the Arizona Department of Health Services (ADHS), Division of Public Health Services/Office for Children with Special Health Care Needs (DPHS/OSCHN). CRS provides a limited scope of services to children who have certain medical, disabling, or potentially disabling conditions which have the potential for functional improvement. AHCCCS eligible CRS children are concurrently enrolled in an AHCCCS acute care plan, or an Arizona Long Term Care System (ALTCS) plan, for their primary health care needs. CRS recipients are included in the acute care or ALTCS plan population from which samples are drawn for acute care or ALTCS plan performance measures. Therefore, AHCCCS does not include CRS in its current performance measurement process.

CRS also is not included in the mandatory performance improvement projects designed by AHCCCS, since these are usually focused on primary care services that are not part of the scope of services provided by CRS. However, CRS is required to develop its own performance improvement projects. One new project is required each contract year. Projects must be approved by AHCCCS prior to implementation. Guidelines for performance improvement projects are included in the *AHCCCS Medical Policy Manual (AMPM),* and participation in performance improvement projects is required in contract.

Three proposals, identified by CRS as performance improvement projects, in varying stages of completion, were reviewed for this EQRO Annual Report. The following are the three CRS proposed projects.

- Increase Appropriate Cleft Lip/Cleft Palate Follow-up Visits
- Increase Accuracy of WeeFIM Assessments
- Improve Pediatric to Adult Transition Services for Youth

Although topics and projects selected by CRS have the potential to positively impact quality of care, functional status, and recipient satisfaction, proposed PIPs have consistently failed to demonstrate an impact on these potential outcomes. The CRS-selected PIPs have not achieved the intended results despite concerted and consistent efforts by AHCCCS to provide technical assistance, and to bring CRS administration into compliance.

AHCCCS has a written *Quality Assessment and Performance Improvement Strategy* to comply with the BBA requirement. On a regularly scheduled basis, AHCCCS monitors and evaluates access to care, organizational structure and operations, clinical and non-clinical quality measures, and performance improvement outcomes. This monitoring is

accomplished through ongoing report and document review, bi-weekly meetings with CRS staff, and an annual on-site operational and financial review (OFR). The process is thorough, complete, and well documented by AHCCCS. Despite the close monitoring, frequent meetings, continuous feedback, and technical assistance provided by AHCCCS, CRS has been slow to embrace the concepts of continuous quality improvement, and has not documented the impact of AHCCCS' monitoring and assistance on outcomes of care, functional status, or recipient satisfaction. However, based on a review of the documents supplied by AHCCCS for this EQRO Annual Report, AHCCCS exceeds CMS requirements for oversight of CRS as a PIHP.

I. INTRODUCTION

Arizona's Medicaid program, known as the Arizona Health Care Cost Containment System (AHCCCS), was started in 1982 and was the first Medicaid program in the United States to be granted an 1115 Waiver. This waiver refers to a certain provision of the Social Security Act that outlines specific requirements for Medicaid. The waiver allows Arizona to operate a demonstration project using a managed care model for delivery of health care services.

Arizona has a long-standing program known as the Children's Rehabilitative Services (CRS) program. CRS was previously known as the Arizona Society for Crippled Children, which was founded in 1929. The Children's Rehabilitative Services program is currently administered through the Arizona Department of Health Services (ADHS), Division of Public Health Services/Office for Children with Special Health Care Needs (DPHS/OCSHCN). Historically, the CRS program operated essentially independent of any significant oversight by AHCCCS. If a child is Medicaid eligible and receives covered services from CRS, then AHCCCS is ultimately responsible for payment. Payment is made through a capitation methodology.

It is important to note that Medicaid eligible children are assigned to an AHCCCS acute care or ALTCS plan for all of their episodic, EPSDT, and other health care needs. However, for those specifically defined conditions covered by CRS, services are delivered through the CRS network of contracted providers.

ADHS/CRS has contracts with several organizations that serve as CRS clinics. These entities are responsible to establish a network of providers, therapists, and other appropriate facilities and services to meet the care needs related to the covered conditions of eligible CRS recipients within their contracted geographic service area (GSA). When a child is identified with a CRS covered condition, the child is referred by the acute care or ALTCS plan to a CRS clinic. The child must be evaluated by the clinic and, if it verifies that the condition qualifies for CRS coverage, the child must receive all care for that condition from the clinic and its contracted provider network.

Because of the Balanced Budget Act (BBA) of 1997, AHCCCS modified its contract with ADHS/CRS to include those elements that are required to monitor and measure quality of care. Contractual modifications included a significantly higher level of oversight and accountability for both agencies. Each Medicaid eligible child in CRS also is assigned to an acute care or ALTCS health plan, and is included in that plan's performance improvement projects and performance measures. Therefore, CRS has only been required by AHCCCS to develop and conduct Performance Improvement Projects, but not to participate in Performance Measures. The BBA of 1997 does require a review by the state of health plan compliance with federal and state law regarding managed care systems every three years. The requirement for an annual External Quality Review Organization (EQRO) report also is in the BBA of 1997. AHCCCS contracted with HCE QualityQuest to perform this EQRO Annual Report for CRS for contract year 2004.

II. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE MEASURES

Arizona Health Care Cost Containment System (AHCCCS), as described in its Quality Assessment and Performance Improvement Strategy, recognizes the need for identifying, tracking, and trending performance measures (indicators) as a component of assessing the overall quality of care delivered to its members. AHCCCS also recognizes that, for these measures to be reliable and valid, the methodology used must be sound and based on nationally recognized standards. AHCCCS, with minor modifications, uses the Health Plan Employer Data and Information Set (HEDIS®) to measure performance in its acute care plans. HEDIS® was developed by the National Committee for Quality Assurance (NCQA) and first released in 1993. It is considered the national standard for measuring and reporting health plan performance. AHCCCS is an active participant with the Centers for Medicare & Medicaid Services (CMS) in the development and use of performance measures for Medicaid managed care programs.

In addition to identifying the performance indicators to be measured, AHCCCS also identified a minimum performance standard, a goal, and a benchmark for each indicator. The benchmarks are based on the goals for health promotion and disease prevention developed by the U.S. Department of Health and Human Services as part of its Healthy People 2000 or 2010 publication. Acute care and ALTCS health plans are contractually required to participate in performance measures. Plans that do not meet the minimum standards must submit a corrective action plan for review and approval by AHCCCS. All health plans are expected to continuously improve their performance measures.

Medicaid eligible CRS recipients are enrolled in the AHCCCS program and assigned to an acute care or ALTCS plan for their primary health care needs. CRS is only responsible for services directly related to a specific condition, such as spina bifida or cerebral palsy. The acute care or ALTCS plan is ultimately responsible for the delivery of all medically necessary health care services, and CRS recipients are included in the acute care and ALTCS plan population from which samples are drawn for plan performance measures. For example, when measuring immunization rates for two year old children, all two year olds are included, even those with spina bifida or cerebral palsy receiving specialized services through CRS.

Because CRS recipients are concurrently enrolled in an acute care or ALTCS plan, the performance measurement process established for acute care and ALTCS plans is not applicable. However, AHCCCS, through its contract with CRS, reserves the right to require performance measures in the future. AHCCCS is in the process of finalizing a new contract with CRS, which will include performance measures specific to its recipients and their unique needs.

III. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE IMPROVEMENTS PROJECTS

Performance Improvement Projects (PIPs) are part of the overall AHCCCS Quality Assessment and Performance Improvement Strategy. The requirement to design and implement performance improvement projects is included in the AHCCCS contract with CRS. The guidelines for conducting PIPs are detailed in the *AHCCCS Medical Policy Manual* (AMPM), Policy 980 in Chapter 900. The AMPM states that "The purpose of PIPs is to assess and improve processes, and thereby, outcomes of care. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted and reported in a methodologically sound manner." [1]

As required in 42 CFR 438.236, performance improvement projects shall include the following components.

- Identify clinical or non-clinical areas for improvement
- Gather baseline data from administrative data and other sources
- Design and implement interventions
- Measure the effectiveness of the intervention
- Maintain and sustain the improvement

Performance improvement projects are intended to take four years to complete. AHCCCS requires, at the end of the first year, that a baseline measurement be established. In the second year, the emphasis is on intervention. A re-measurement to determine if improvement has been made is conducted in the third year. If improvement is demonstrated, measurement is repeated in the fourth year documenting sustained improvement. AHCCCS requires all contractors to submit, on an annual basis, a quality management and evaluation plan. The QM plan is the vehicle used to propose new PIPs and provide updates and progress reports on those in process. AHCCCS must approve all PIP proposals prior to implementation. AHCCCS incorporated the following steps into a tool for Quality Management staff to use in reviewing PIP proposals.

- Review the selected study topic(s)
- Review the study question(s)
- Review selected study indicator(s)
- Review the identified study population
- Review sampling methods (if sampling was used)
- Review the MCO's/PIHP's data collection procedures
- Assess the MCO's /PIHP's improvement strategies
- Review data analysis and interpretation of study results
- Assess the likelihood that reported improvement is "real" improvement
- Assess whether the MCO/PIHP has sustained its documented improvement

Three proposals identified by CRS as performance improvement projects, in varying stages of completion, were reviewed for this EQRO Annual Report.

- Increase Appropriate Cleft Lip/Cleft Palate Follow-up Visits
- Increase Accuracy of WeeFIM Assessments
- Improving Pediatric to Adult Transition Service for Youth

Each of the three performance improvement projects will be discussed separately.

Increase Appropriate Cleft Lip and/or Cleft Palate Follow-up Visits

A. Objectives

The proposal for this PIP was submitted in December, 2002 and approved by AHCCCS in March, 2003. The purpose of this project was to determine the percentage of CRS recipients with cleft lip and/or cleft palate, between two and three years of age, who had a dental visit in the previous contract year. Most children with cleft lip and/or cleft palate have associated dental anomalies that may adversely affect normal growth and development. Early intervention may limit potential negative outcomes. CRS Guidelines to Care for Cleft Lip/Palate require Regional Contractors to have all children, between two and three years of age, be evaluated by a dental provider. [2]

B. Description of Data Collection Methodology

The study question is "What is the percentage of children between the ages of two and three who have a diagnosis of cleft lip and/or cleft palate being screened by a pediatric dentist?" The study indicator is worded exactly as is the study question. The indicator criteria define the HCPCS codes used to identify a dental visit and describe the age parameters used in data collection. However, no enrollment criteria are defined, such as length of time in the program or whether individuals included in the study population are enrolled in the AHCCCS program.

The denominator is defined as the number of children receiving services through CRS (overall and by individual Regional Contractors) who had a diagnosis of cleft lip and/or cleft palate (ICD-9 codes 749.00 through 749.24), who turned age three during the review period.[3] The denominator includes ICD-9 codes and age parameters. The numerator is defined as the number of children in each denominator who had a dental visit between their second and third birthday.[4]

The CRS encounter/claims system is identified as the sole source for data collection. No lag time was built into the data collection design. The data collected was based on percentages and reported by Regional Contractor and in the aggregate. A chi-squared analysis was planned to evaluate the significance of change from year-to-year. The baseline report, submitted in December 2003 by CRS, identified barriers to performing the study, such as information not being available in the CRS data system and services potentially being provided by other insurance plans. The goal established was that 85%

of CRS recipients with cleft lip and/or cleft palate will have a dental evaluation between the age of two and three years. Improvement strategies also were identified in the baseline report.

As a result of ongoing monitoring and technical assistance provided by AHCCCS to CRS, a revised PIP methodology for the cleft lip/cleft palate study was submitted to AHCCCS in July 2004. Although outside the scope of this EQRO Annual Report, the revised methodology identifies alternative data sources. Further follow-up will be included in the CY 2005 EQRO Annual Report.

C. Description of Data

The only data provided to date is the baseline report, which was measured from 07/01/2002 to 06/30/2003. The findings are summarized in Table 1.

Table 1
Children with Cleft Lip and/or Cleft Palate with a Dental Visit Between 2 and 3 Years of Age

Region	Numerator	Denominator	Percent
Northern Region	1	16	6.3%
Central Region	7	130	5.4%
Southern Region	5	50	10.0%
Western Region	0	9	0.0%
Statewide	13	205	6.3%

D. Review of Analysis Methodology

A presentation of the baseline data was the only review completed at the time of this EQRO Annual Report. The findings were significantly lower than the established goal. The analysis was limited to potential additional sources of data, such as from AHCCCS. CRS does not address the potential reasons for encounters being so low. For example, were referrals not made, appointments not kept, or encounters recorded at the acute care or ALTCS health plan in which the CRS recipient is enrolled for his/her primary health care.

Documents related to the history of this PIP demonstrate ongoing review of the study design and methodology by AHCCCS and CRS. These reviews, combined with ongoing discussions between AHCCCS and CRS administration, demonstrate efforts to improve the study design.

E. Assessment of Strengths and Weaknesses

The impact is unquestioned of early intervention on mitigating the impact of dental anomalies in children with cleft lip/cleft palate. A PIP designed to ensure that early intervention occurs would be appropriate and clearly linked to quality. The interventions would lead to improving the functional status and satisfaction of CRS recipients with cleft lip and/or cleft palate, and their families. For example, nutrition would be improved by the ability to chew a variety of foods, which would have a positive impact on growth. Speech also would be improved, allowing for improved oral communication. Both would have a positive impact on recipient satisfaction and general growth and development. The proposal, as presented, did not attempt to look at outcomes or improving health status, functional status, or recipient satisfaction over time. Another weakness of the proposal is its reliance on encounter data. A program with a population that has more than one source of care for the same services cannot use encounter data from only one place as a reliable source of information.

No documentation or discussion was included on how this PIP topic was selected and approved by CRS. No reference is made to the AHCCCS required committee approval process, and there is no mention of medical director involvement.

F. Conclusions

According to utilization data included in the CY 2004 QM/UM Plan, cleft lip and/or cleft palate affects 7.46% (1,301) of the 17,440 children in the CRS population. Most of the cleft lip and/or cleft palate children visit a dentist between four and nine years of age, and most dental procedures occur between 10 and 14 years of age. Only 11 encounters were reported for children between one and three years of age. Since the study population was an even smaller subset of the one to three year age group, it would be expected that dental encounters for the two to three year old age group with cleft lip and/or cleft palate would be low. Since the purpose of a PIP is to improve a process, and thereby outcomes, the utilization data cited supports the development of a PIP to address this area and improve adherence to the CRS care guidelines. CRS might have focused earlier in the project on identifying alternative data sources in order to ensure reliable, valid conclusions.

While AHCCCS did approve the study proposal, they did not accept the baseline report or the interim report submitted by CRS. AHCCCS requested that CRS re-design the project to bring it into compliance with AHCCCS policy and contract requirements. AHCCCS held several meetings with CRS Quality Management staff to guide them in the PIP development process. A review of this performance improvement project was included in the CRS CY 04 Operational and Financial Review. A specific recommendation from the OFR required CRS to re-design this project. CRS submitted a new proposal as part of the corrective action plan; however, that occurred after June 30, 2004, and is outside the scope of this EQRO Annual Report.

Increase Accuracy of WeeFIM Assessments

A. Objectives

This PIP proposal was submitted in December 2003 and reviewed by AHCCCS in January 2004, with only minor recommended changes to the timeline. CRS sent its revision to AHCCCS in March, 2004, documenting the changes. The purpose of this PIP was to allow CRS to maximize use of the WeeFIM system. Wee refers to the children's version of the FIM, or Functional Independence Measure. The WeeFIM system is part of the Uniform Data System for Medical Rehabilitation (UDSMR) and was developed with input from a number of national organizations, such as the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation. The UDSMR's mission is to enable health care providers to document the outcomes, processes, and perceptions of care in a uniform way.[5] CRS requires its Regional Contractors to complete a WeeFIM form at specified intervals for children with spina bifida, cerebral palsy, and pre-op and/or post-op rhizotomy procedures. CRS's ability to use the system is dependent on Regional Contractors submitting the completed forms.

B. Description of Data Collection Methodology

The study question is "What is the percentage of clean assessments submitted to Arizona Department of Health Services/Office for Children with Special Health Care Needs (ADHS/OCSHCN)." Critical features of the study, such as the WeeFIM tool, spina bifida, cerebral palsy, and pre-op/post-op rhizotomy procedures, are not included in the study question. The study indicator is worded almost the same way as the study question.

The study population included children currently receiving services through the CRS program with a diagnosis of spina bifida, cerebral palsy, or a pre-op/post-op rhizotomy procedure. The ICD-9 codes used were not identified. Children with a rhizotomy procedure are a subset of those with cerebral palsy; the potential for duplication exists. There is no indication that enrollment in the AHCCCS program, age, or minimum enrollment periods, were considered.

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There is no documentation to explain how this topic was selected, how it was reviewed and approved, or by whom. No reference is made to the AHCCCS required committee approval process, and there is no mention of medical director involvement.

C. Description of Data

All data for this project were obtained from the ADHS/OCSHCN WeeFIM data system. The data presented in the baseline and interim report included the number and percentage of clean WeeFIM assessments submitted by the Regional Contractors to CRS. These findings are summarized in Table 2.

Table 2
The Percentage of Clean WeeFim Assessments Submitted to ADHS

Regional Contractors	Measurement	Time Period	Numerator	Denominator	Percentage
Northern (Flagstaff)	Baseline	Fiscal Year 2003	3	44	6.8%
	Measurement 1	April, May, June 2004	11	11	100.0%
Central (Phoenix)	Baseline	Fiscal Year 2003	238	811	29.3%
	Measurement 1	April, May, June 2004	92	92	100.0%
Southern (Tucson)	Baseline	Fiscal Year 2003	400	413	96.8%
	Measurement 1	April, May, June 2004	43	43	100.0%
Western (Yuma)	Baseline	Fiscal Year 2003	9	70	12.8%
	Measurement 1	April, May, June 2004	17	17	100.0%
Statewide	Baseline	Fiscal Year 2003	650	1338	48.5%
	Measurement 1	April, May, June 2004	163	163	100.0%

D. Review of Analysis Methodology

The analysis plan, as presented in the proposal, is simply a reiteration of the data collection process. No analysis was performed. No assessment or discussion of the accuracy of the WeeFIM assessments was included in the proposal, nor was there mention of how the tool is used or its proposed impact on health outcomes.

E. Assessment of Strengths and Weaknesses

The WeeFIM system was developed by the Uniform Data System for Medical Rehabilitation. The WeeFIM System documents functional performance in children and adolescents with acquired or congenital disabilities and provides a method of evaluating outcomes for individual patients, groups of patients, and pediatric rehabilitation and habilitation programs.[6] CRS requires its contactors to participate in the WeeFIM Functional Independent Measurement System. Assessments are to be performed at specific intervals on the same individual over time. As a functional outcome measurement system, WeeFIM was adopted by CRS to assist in program evaluation. It is not clear how long the system has been in use by CRS or what they do with the data and reports generated by the system. How CRS uses WeeFIM assessments to impact health outcomes or enrollee satisfaction is not discussed in the PIP proposal or follow-up reports.

The only intervention identified in the interim report was the purchase of a UDSMR system upgrade that allowed for real time direct entry of data into the WeeFIM system. This upgrade resulted in 100 % completion of forms.

CRS now had the information needed to begin assessing functional improvement of its recipients with spina bifida and cerebral palsy over time. This was the point at which the

substantive work related to performance improvement should have begun. Instead, CRS proposed that this PIP had been completed.

F. Conclusions

After a baseline measurement and one follow-up measurement, CRS reported 100% compliance with its contractors completing a WeeFIM assessment and expected that the project would end. Ending the project at this point demonstrates a lack of understanding of the purpose and intent of performance improvement projects, as each project is intended to occur over a three to four year period. The Background and Purpose sections of the PIP proposal could be improved to more clearly state the connection between completeness/accuracy of the WeeFIM data and functional status or quality of care. Although the title of the project is "Increase Accuracy of WeeFIM Assessments," accuracy in completing the assessment tool is not addressed. The study focuses solely on whether the form is filled out, not whether the information is accurate or used to impact quality of care in any way.

This project was limited to measuring the percentage of completed assessments submitted to the system and did not clarify the link between completed assessments and outcomes. AHCCCS did approve the proposal and, in a letter dated October 21, 2004, AHCCCS indicated that the October 20, 2004 interim report for this project was received. AHCCCS planned to respond with comments as part of its overall response to the proposed CYE 2005 Quality Management/Utilization Management Annual Plan.

Improving Pediatric to Adult Transition Services for Youth

This proposal was submitted by CRS to AHCCCS on December, 2004. Approval by AHCCCS was pending at the time of this EQRO Annual Report.

A. Objectives

The purpose of this project is to improve transition services for adolescents receiving services through CRS. Transition planning allows young people to optimize their ability to function as adults. CRS requires its Regional Contractors to initiate transition services for recipients at 14 years of age. This project was designed to determine the percentage of children who have documented transition plans initiated and to develop interventions aimed at eliminating the barriers to providing these services when identified.

B. Description of Data Collection Methodology

Three study questions were identified in this PIP proposal.

- What percentage of CRS recipients have a transition plan initiated and documented by age 15 years within the study period?
- What are the barriers to the initiation of transition planning and documentation?
- How do the percentages compare by CRS contactor site?

While more than one study question is acceptable in a project, each must have a defined indicator to answer the question. However, for this PIP, only one study indicator is identified. The indicator defines what documentation must be found to be valid. However, the study indicator does not address outcomes, such as health or functional status, recipient satisfaction, or valid proxies of these outcomes.

The study population, as described, includes CRS recipients enrolled in AHCCCS who reached 15 years of age by June 30, 2005 and had at least one encounter from July 1, 2004 to June 30, 2005. The sample selection states that all CRS recipients who meet these criteria will be included in the study.

The denominator is defined as CRS recipients between 15 and 16 years of age on June 30, 2005, who had at least one encounter from July 1, 2004 to June 30, 2005.

The numerator is defined as the number of CRS recipients from the denominator who had a documented transition plan initiated within the study period.

The study population, sample selection, denominator, and numerator are consistently defined. However, the data collection section states that a random sample will be extracted from CRS contractor databases, which is inconsistent with what is described in the sample frame. Further clarification of sample selection is needed.

The data collection plan includes a combination of administrative data and medical record abstraction. No information is provided to define the administrative data. A tool for medical record abstraction is in development. A plan for data validation is described, including education to ensure inter-rater reliability.

The staff to be used in data collection are not described. The analysis plan describes how the baseline data will be obtained and comparisons made between Regional Contractors. Barrier analysis and focus groups are discussed, but the methodologies to be used have not been developed yet. This PIP is in the proposal stage, and further review is not possible at the time of this EQRO Annual Report. AHCCCS continues to work with CRS to address some of the issues identified in this section of the EQRO Annual Report. The final methodology for this PIP has been incorporated into the CRS contract renewal for CY 05 as a mandated PIP, designed to address a unique aspect of CRS.

C. Conclusions

This performance improvement project is significantly different than the previous two submissions. It is the first proposal submitted by a Medical Director. The language, organization, and methodology are more robust, and demonstrate a better understanding of the purpose and intent of performance improvement projects. The methodology provided to the EQRO was not a final version; therefore, any further conclusions would be premature. A full review of this PIP will be included in the CY 2005 EQRO Annual Report.

Notes

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR 400, 430, et al., Final Protocol, Version 1.0, February 11, 2003, p. 1.

[2] Arizona Department of Health Services, Office for Children with Special Health Care Needs, Quality Improvement Project Methodology Increase Cleft Lip/Cleft Palate Follow-up Visits, p. F-2.

[3] ADHS/OCSHCN, p. F-3.

[4] ADHS/ OCSHCN, p. F-4.

[5] UDSMR, Uniform Data System for Medical Rehabilitation, as of April, 2005. http://www.udsmr.org/udsmr_missionstatement.php

[6] UDSMR, WeeFIM System, Product Information, as of April 2005. http://www.udsmr.org/pdfs/2005_WeeFIM_II_Product_Information_Slick.pdf

IV. REVIEW, ANALYSIS, AND SUMMARY OF AHCCCS COMPLIANCE WITH MEDICAID MANAGED CARE FEDERAL AND STATE REGULATIONS

A. Objective

The Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies that contract with Medicaid managed care organizations (MCOs) "to develop a state quality assessment and improvement strategy that is consistent with standards established by the Department of Health and Human Services (DHHS)."[1] BBA provisions also apply to prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case management programs (PCCMs).Federal requirements are broadly defined under the following categories.

- Enrollee Rights and Protections
- Quality Assessment and Performance Improvement
    - Access Standards
    - Structure and Operations Standards
    - Measurement and Improvement Standards
- Grievance System

AHCCCS has a written Quality Assessment and Performance Improvement Strategy to comply with the BBA requirement. The document was developed with input from members, the public, and other stakeholders. The document is reviewed annually and/or when a significant change occurs. AHCCCS reports Quality Strategy activities, findings, and actions to members, other stakeholders, contractors, the governor, legislators, and the Center for Medicare & Medicaid Services (CMS).[2] In a letter received by AHCCCS on August 4, 2004, CMS extended contract approval for the contract with CRS through June 30, 2005, ensuring that the contract met the requirements established by the BBA of 1997 and 42 CFR Part 438.[3] On a regularly scheduled basis, AHCCCS monitors and evaluates access to care, organizational structure and operations, clinical and non-clinical quality measurements, and performance improvement outcomes though the following activities.

- Annual on-site operational and financial reviews
- Review and analysis of periodic reports
- Review and analysis of program specific performance indicators and Performance Improvement Projects [4]

B. Description of Data and Information Collection Methodology

The contract between AHCCCS and CRS contains the following list of periodic reporting requirements.

Report	When Due
Quarterly Financial Report	60 days after the end of each quarter
Certification Statement	With each Quarterly and Annual Report
Draft Annual Audit Report	90 days after the end of each fiscal year
Draft Management Letter	90 days after the end of each fiscal year
Final Annual Audit Report	120 days after the end of each fiscal year
Final Management Letter	120 days after the end of each fiscal year
Accountant's Report on Compliance	120 days after the end of each fiscal year
Reconciliation – Annual Audit and Plan Year-to-Date Financial Report Information	120 days after the end of each fiscal year
Financial Disclosure Report	120 days after the end of each fiscal year
Encounter Data – Magnetic Tape Submission	Monthly, according to established schedule
Corrected Pended Encounter Tape	Monthly, according to established schedule
New Day Tape	Monthly, according to established schedule
Medical Records for Data Validation	90 days after the request is received from AHCCCS
Quarterly Grievance Report	45 days after the end of each quarter
Quality Management/Utilization Management Plan and Evaluation	Annually on December 15th
Quality Improvement Project (QIP) Proposal (initial/baseline year of project)	Annually on December 15th
QIP Interim Report (intervention/ measurement year(s) of the project)	Annually on December 15th
Provider Fraud/Abuse Report	Immediately following discovery
Eligible Person Fraud/Abuse Report	Immediately following discovery
Cultural Competency Plan	45 days after the first day of a new contract year

These reports are reviewed by AHCCCS on an ongoing basis within the department responsible for the area of the reports. In addition to these reports, the contract also requires CRS to submit the following documents to AHCCCS for review and approval.

- A Written Description of Services including the diagnostic, therapeutic and restorative services available, limitations and exclusions for each CRS covered condition, duration of service coverage, and the criteria used to determine service limitations and exclusions
- A Clinic Contact List that includes clinic name, the clinic manager and medical director, address, phone number, and clinic days and hours; CRS shall update this contact list quarterly, or more frequently, if necessary
- A Recipient Handbook including, at a minimum, the items listed in the AHCCCS, DHCM CRS *Recipient Information Policy*

- A Provider Network Development and Management Plan
- A CRS Policy Manual, with copies of final policies submitted to AHCCCS at least ten business days prior to implementation
- Physician Incentive Plan Disclosures
- All subcontracts for the provision of AHCCCS covered services
- Requests for Proposals to provide AHCCCS covered services
- Legislative Proposals and Initiatives–CRS shall provide AHCCCS with copies of proposals for legislative changes, Arizona Administrative Code program initiatives, and any other policy initiatives that may affect CRS services, coverage, or any aspects of medical care

Upon receipt by AHCCCS, the documents listed above are forwarded to the department at AHCCCS that has the expertise needed to analyze the content of the document. Where applicable, checklists have been developed for staff to use in the review process, ensuring that all required Federal and State requirements are addressed. AHCCCS responds in writing, and either approves the document or requests revisions.

In addition to reviewing the deliverables described above, AHCCCS conducts an on-site review annually. The on-site review allows AHCCCS the opportunity to review and validate CRS compliance with contract requirements. AHCCCS refers to these on-site reviews as Operational and Financial Reviews (OFRs). The process used for these reviews has been refined over several years. A uniform tool is used to review each acute care and ALTCS health plan and, when possible, the same staff is assigned to conduct the review. This process is designed to ensure consistency. The format of the review follows nationally recognized processes and is modeled after NCQA.

The actual on-site activities include document review, staff interviews, and observations of operations. In this way, the review staff is able to get a complete picture of CRS performance. This process is consistent with the protocol developed by CMS that includes the following recommended activities.

- Planning for the review
- Obtaining background information
- Document review
- Conducting interviews
- Collecting accessory information
- Reporting results

For contract year 2004, AHCCCS identified the following objectives for the CRS Operation and Financial Review.[5]

- To determine if the Contractor satisfactorily meets AHCCCS' requirements as specified in the Contract Year Ending 2004 (CYE 2004) contract, AHCCCS policies, and the Arizona Administrative Code (AAC)
- To increase AHCCCS knowledge of the Contractor's operational and financial procedures

- To provide technical assistance and identify areas where improvements can be made, as well as identifying areas of noteworthy performance and accomplishment
- To determine if the Contractor is in compliance with its own policies, and to evaluate the effectiveness of those policies and procedures
- To perform oversight as required by the Centers for Medicare & Medicaid Services (CMS), in accordance with AHCCCS's 1115 waiver

Upon completion of the Operational and Financial Review, key program areas are scored, based on the following scale.

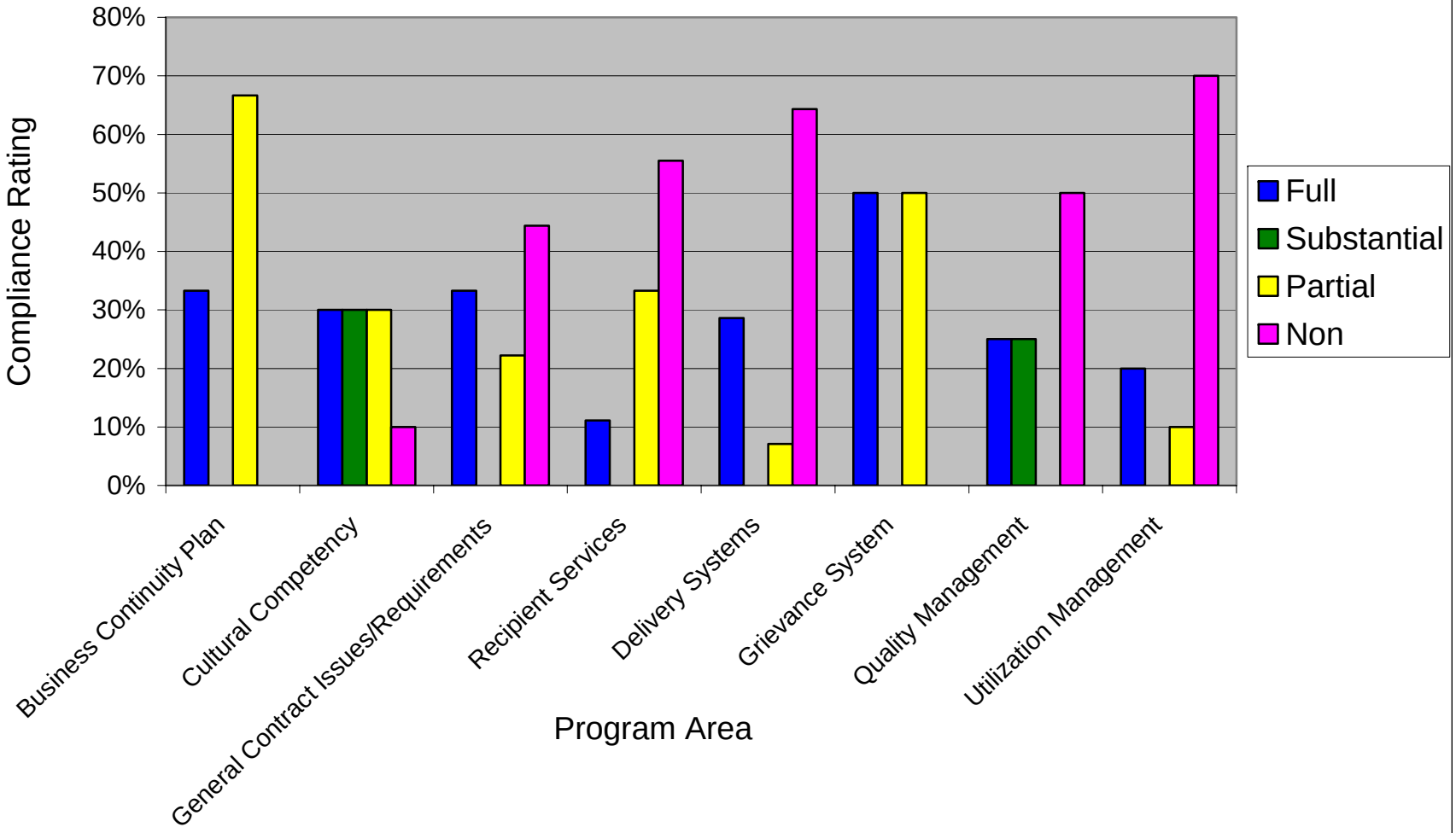
- Full Compliance 90-100% agreement with standard(s)
- Substantial Compliance 75-89% agreement with standard(s)
- Partial Compliance 50-74% agreement with standard(s)
- Non-Compliance 0-49% agreement with standard(s)

A written report that includes findings and recommendations is then produced. A summary of the findings of CRS for CY 04 is displayed in Table 3 and Figure 3.

Table 3
Summary of CRS CY 2004 OFR Findings

Program Areas	Number of Standards Reviewed	Compliance Rating for Standard			
		Full	Substantial	Partial	Non
Business Continuity Plan	3	33.3%	0.0%	66.7%	0.0%
Cultural Competency	10	30.0%	30.0%	30.0%	10.0%
General Contract Issues/Requirements	9	33.3%	0.0%	22.2%	44.4%
Recipient Services	9	11.1%	0.0%	33.3%	55.5%
Delivery Systems	14	28.6%	0.0%	7.1%	64.3%
Grievance System	2	50.0%	0.0%	50.0%	0.0%
Quality Management	4	25.0%	25.0%	0.0%	50.0%
Utilization Management	10	20.0%	0.0%	10.0%	70.0%
Total	61	26.2%	6.6%	21.3%	45.9%

Figure 3: Summary of CRS CY 2004 OFR Findings



In addition to the foregoing findings, 79 recommendations were made in the final report. In accordance with contract requirements, CRS prepared and submitted a corrective action plan to AHCCCS that addressed each recommendation.

C. Description of Data and Information

The data and information used in the review process were the actual documents used in daily operations. For example, a CRS recipient information packet ready for mailing, an actual signed provider contract, the actual grievance log, authorization logs, and reports produced by CRS staff were reviewed. Mock-ups were not accepted.

The information and data used in the production of "system driven" reports, such as reports based on encounter data, are produced from the CRS database. It is not clear whether or not the extensive data validation process that AHCCCS uses to review the acute care plans was applied to CRS. AHCCCS did not provide information on the methodology used for validating the data used to produce CRS reports.

D. Review of Analysis Methodology

In its oversight of CRS, AHCCCS uses a combination of methods designed to complement each other and provide as complete a picture as possible of CRS operations. At least annually, AHCCCS reviews and approves, or requests revisions to, critical written materials used by CRS in fulfillment of its contract. Examples of these materials are listed below.

- Recipient handbook
- Network evaluation and management plan
- Quality Management evaluation and plan
- Cultural Competency evaluation and plan

These documents are formally reviewed and a written response provided to CRS. Checklists are used to ensure that all required elements are included in the review. Staff with content expertise is used in the review process. Biweekly meetings are held with CRS staff to continuously review and monitor progress in selected areas, such as quality management and performance review projects. In addition to review and monitoring, these meetings provide a forum for ongoing education, technical assistance, and guidance to CRS staff.

AHCCCS also conducts an annual on-site Operational and Financial review that includes a review of provider contracts, credentialing files, interviews with staff, and observations of selected operations. AHCCCS maintains a master review tool that incorporates all State and Federal requirements. The acute care plan review tool was modified for use in conducting the CRS OFR because CRS is not an acute care health plan. Not all items are reviewed each year. Some items not included in the CY 04 review are included in the

matrix for the CY 05 review. The remaining items will need to be reviewed by AHCCCS in CY 06.

In addition, AHCCCS regularly obtains feedback from the acute care and ALTCS plans on CRS issues. The acute care and ALTCS plans are likely to be the first to know if CRS recipients or providers are having difficulty navigating the CRS system, such as scheduling an appointment, and they report these problems to AHCCCS on an ongoing basis. The monthly meeting with plan medical directors provides a forum to keep this dialogue open. The CRS medical director is invited to attend these meetings. In combination, these oversight activities provide AHCCCS with an accurate assessment of CRS compliance with State and Federal requirements.

E. Assessment of Strengths and Weaknesses

Of the 61 standards reviewed for the CY 2004 OFR, 32.8% were scored as being in full or substantial compliance with contractual requirements, while 67.2% were scored as partial or non-compliant. Table 3 (page IV-4) and Figure 3 (page IV-5) illustrate the CY 2004 OFR findings, identifying specific areas of strength and weakness. In response to the findings and recommendations from AHCCCS, CRS submitted a comprehensive correction action plan (CAP). The CAP developed by CRS, revised in January 2005, is organized and thoughtful, demonstrating a commitment to recognizing and addressing identified deficiencies, and implementing recommended changes.

The CAP, and documents included as attachments to the CAP, indicate that significant work has been done to bring the CRS program into full compliance. A full review of the progress made as a result of the CAP will be included in the CY 2005 EQRO Annual Report.

F. Conclusion

Based on a review of the documents supplied for this EQRO Annual Report, AHCCCS exceeds the Centers for Medicare & Medicaid Services (CMS) requirements for oversight of CRS as a PIHP and is in full compliance with 42 CFR Parts 400, 430, et al.

Despite the close monitoring, frequent meetings, continuous feedback and technical assistance provided by AHCCCS, CRS has been slow to embrace the concepts of continuous quality improvement and has yet to document any impact of this monitoring and assistance on outcomes of recipient care, functional status, or recipient satisfaction.

Notes

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR 400, 430, et al., Final Protocol, Version 1.0, February 11, 2003, p. 1.

[2] State of Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, December 2003, p. 3.

[3] Department of Health and Human Services, CMS Region IX, "To Arizona Health Care Cost Containment System," 4 August 2004, Approval of CRS contract by CMS.

[4] DHS, CMS Region IX, p. 8.

[5] AHCCCS, CRSA OFR CYE 04 Operational and Financial Review, p. 1.

V. SUMMARY AND RECOMMENDATIONS

Summary

AHCCCS has the infrastructure, systems, and processes in place to provide the required oversight of its contractors. The process is thorough, complete, and well documented. Methods used include ongoing report and document review, and an annual on-site operational and financial review. Requirements of CRS are identified in policy and/or the AHCCCS contract with CRS. Despite appropriate oversight and excellent documentation, it appears that CRS is not meeting established standards.

The performance improvement projects proposed by CRS consistently failed to demonstrate an impact on quality of care or recipient satisfaction. Despite close monitoring, technical assistance, and oversight by AHCCCS, CRS has not been successful in demonstrating the ability to select and implement performance improvement projects that effectively result in improving health status or outcomes, or have a positive impact on recipient satisfaction or their general growth and development.

CRS and AHCCCS have been working together to serve Medicaid enrolled children with special health care needs since the AHCCCS program began in 1982. Medicaid children receiving services through the CRS program are concurrently enrolled in an AHCCCS acute care or ALTCS plan. Eight-five percent of the CRS population is Medicaid eligible. The acute care or ALTCS plan provides the majority of the health care delivered to these children.

Recommendations

CRS should be encouraged to develop performance improvement projects on services that are unique to CRS, such as improvements in functional status or working with the parent action councils, to avoid measurement difficulties associated with dual enrollment.

The WeeFIM tool, and the data collected, can be used to measure improvements in functional status for children with certain identified conditions or disabilities. Given the unique nature of the population receiving services through the OCSHCN/CRS program, a performance improvement project targeted at measuring improvements in functional status would meet all BBA requirements. The study topic would target improvement in a specific and relevant area of clinical care, would address a significant portion of CRS recipients, and would have a potentially significant impact on recipient health and functional status. CRS has already established the use of this tool, and has successfully resolved issues relating to having tools completed. Future focus might be placed on the accuracy of the information collected, and then further developed to set goals for measuring and sustaining improvement. Data collected would then be valid and reliable. Since the tool is widely used, results could be compared with national benchmarks and averages, in additional to local and regional comparisons.

The Transition Services PIP already has been incorporated by AHCCCS into the CY 2005 contract renewal as a mandated PIP. The study design for this PIP demonstrated notable improvements over previous efforts in many areas. Continuing assistance and oversight by AHCCCS' Quality Management staff to CRS will have a significant effect on performance improvement planning and outcomes in future years.

Despite consistent oversight from AHCCCS, and the technical assistance provided by its Quality Management unit, CRS's CY 2004 QM Plan still does not define its QM Committee. Since the QM Committee, through the medical director, should be responsible for all quality management activities and performance improvement projects, the structure of the QM Committee and the role of the medical director should be clearly defined.

CRS has developed a comprehensive corrective action plan in response to the CY 2004 OFR findings and recommendations, and has begun to implement changes necessary to achieve full compliance in the standards measured. Ongoing technical assistance and collaboration with AHCCCS administration will be helpful in achieving and sustaining improved performance. Based on the documents reviewed for this EQRO Annual Report, significant progress is already evident.

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